of the two widely held viewpoints on how best to prevent nuclear war: to freeze first, then trust to negotiations. The viewpoint held by most persons with the best knowledge of the Soviets is to first motivate them to reduce armaments by modernizing our own.

The Communist party's aim is to impose a communal way of life on all peoples by violence and deceit—much as Hitler also outlined for the Nazi party in *Mein Kampf*. Hindsight suggests that Neville Chamberlain's trust of Adolph Hitler cost hundreds of millions of lives (some in fire storms similar to those of nuclear war). The equivalent of our second viewpoint above was Churchill's plea to modernize deterrents. The biggest policeman is the one least apt to be challenged to fight. The best way to avoid war is to stay strong—according to George Washington.

In case you need knowledgeable authors to balance the views on prevention of nuclear war, I suggest physicist William Shuler, Lawrence Laboratory, Livermore, California, who writes, "What could stop the Soviets from violating the freeze? I, for one, do not want to live under their system." Also, Assistant Secretary of Defense Richard Perle seems to articulate great knowledge of factors for prevention of nuclear war. When we question the need for surgery, are we wise to hear from the surgeons (preferably in the same issue)? When we have symposia on the horrors of biological warfare or of chemical warfare (very appropriate subjects for future *WJM* issues) would we better avoid inbreeding of ideas by including the biologists, the chemists and, above all, those we have made responsible for prevention?

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TO THE EDITOR: *The Western Journal of Medicine* is to be commended for publishing the symposium on the Medical Consequences of Nuclear War in February. Although we have lived with an awareness of this increasing problem since 1945, it has appeared to have little effect on most of our lives. There have been, however, important psychological phenomena. Undoubtedly, some denial of the seriousness of the issue is a partial explanation of our silence until the world now has 60,000 nuclear weapons. A subconscious influence on our society has probably been a factor in problems of crime and personal strife of many types.

Carefully studying the almost incomprehensible medical, social and environmental problems, the reader may feel overwhelmed and quite depressed. After a period of reflection and consideration of this subject, many have found an energizing realization that the horrible scenario has not taken place and that this can and must be avoided. The prevention of a nuclear disaster may well be the most important medical issue in history.

Peace movements have come and gone over the years, but there is presently a growing momentum, including nuclear arms control, that is not about to stop. The reason is simply that there has never been a situation like we have today, and there is now no acceptable alternative to truly investigating international conflict resolution. This is not a naive concept. If clear thinking can prevail, and it probably will, we can be optimistic not only that nuclear war can be avoided, but that a new level of human understanding can come about. Such beautiful dreams are not new and attempts at world government with policing activities have been only partially successful, but again there has never been an adequate reason to make it work. As Dr Judith Lipton said, "Yet, by beaking through the denial and fatalism and becoming involved in an active way on behalf of our children and the planet, we have an opportunity to find enhanced meaning."[1] The "Medical Consequences of Nuclear War" is heavy reading, but there is possibly the greatest opportunity that mankind has been offered—just over the horizon.

In primitive times, people honestly had fear of the unknown on the other side of the mountain. Extensive resources, experience and communication have eliminated to a large degree that enormous stumbling block. There is no choice at this time but to honestly negotiate for peace in the world and for control and the gradual elimination of nuclear weapons. We should not feel helpless and, therefore, become ineffective because of the magnitude of the problem. Physicians continue to work for life and health and for the prevention of epidemics and disease.

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EDITOR'S NOTE

The above letters are representative of many more that have been received from obviously concerned readers who have taken the time to respond to the symposium on the Medical Consequences of Nuclear War which appeared in the February issue. The editors believe these fairly reflect most of the comments received. Because of space limitations it is likely that no further correspondence will be published concerning this symposium.

—MSMW

No Elbow Damage in Young Baseball Pitchers

TO THE EDITOR: As a physician and youth-league baseball coach, I have been asked whether pitching imposes significant risk of enduring damage to the elbows of young players. Only recently has this issue been subjected to scientific investigation.

Gugenheim and co-workers[1] examined 595 Little League pitchers ages 9 to 13 in Houston. It was noted that elbow x-ray findings fall into two categories: (1) quite common anatomic variants that do not correlate with any symptoms or problems and (2) quite uncommon, potentially disabling abnormalities (osteochondrosis/avascular necrosis/osteochondritis dissecans) that are apparently unrelated to athletics. No correlation

was found between years of pitching experience and any elbow symptoms or problems.

Larson and associates[2] examined 120 pitchers ages 11 and 12 in Eugene, Oregon. There were no statistically significant correlations or interrelations found regarding pitching experience, symptoms, elbow deformities or x-ray findings. The authors concluded that "pitching demands in Eugene have not been demonstrated to be detrimental to the immature throwing arms."

Responding to concern about the possibility that adverse effects might be delayed in their appearance, Francis and associates[3] studied 328 Brigham Young University students who had played youth-league baseball, and compared them with 70 students with no previous baseball experience. No significant difference was seen in incidence of residual damage, or in residual injury among positions played or years of experience. The conclusion was that "participation in organized baseball as an adolescent has no enduring deleterious effect on the throwing elbow."

Likewise, Grana and Rashkin[4] studied 73 Oklahoma City senior high school pitchers. No significant relationships were found between occurrence of symptoms and number of seasons played, individual pitching traits, asymmetry on physical examination or asymmetry on x-ray examination of the elbow.

In other words, recent studies tend to contradict the widely held belief that pitching a baseball imposes significant risk of enduring damage to a young player's elbow.

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CSN Codes for Specialized Occupational Medicine Services

TO THE EDITOR: The excellent collection of articles on occupational medicine topics in the December 1982 issue will be a stimulus to the provision of occupational medicine services by providers in the West. We recently proposed a set of model service codes for specialized occupational medicine services compatible with the format of the 1974 revision of the California Relative Value Studies (RVS)[1] and are using it for routine billing and administrative procedures. We propose it as a standard for other medical groups and for possible inclusion into the planned update of the California Standard Nomenclature (CSN) directed by the 1981 House of Delegates of the California Medical Association.

The majority of clinical services provided by occupational medicine practitioners are comparable to those already encoded in the CSN, differing only in the cognitive skills of the practitioner. A few common services are unique to occupational medicine, however, because they pertain to on-site plant visits, extensive consultations with employers, and urgent consultations to deal with a hazardous situation or other problem. These services have no identifiers in the present CSN, but occur sufficiently often to require a code number for billing and data management purposes.

The 1974 RVS has a gap in the numerical sequence in the 98000 series; these numbers are also unused in the AMA Current Procedural Terminology. Why this gap exists is not known, but its placement just before the "Special Services" section is very fortunate. We developed a coding system within the 98000 sequence (Table 1) which is based on the following scheme: The third digit represents *activity* (0 = exploratory discus-

TABLE 1.—*Proposed Numerical Codes for Specialized Occupational Medicine Services, Compatible With CSN*

Suggested Code	*Name of Service*	*Description of Service*
98001	Initial On-Site Consultation	Visit to client's location to ascertain client's needs, requiring approximately 1 hour.
98011	Initial Office Consultation	Visit by client to provider's office to ascertain client's needs, requiring approximately 1 hour.
98101	Consultation Visit, On-Site	Visit to client's location to evaluate a particular problem.
98131	Routine Telephone Consultation	Telephonic consultation concerning an uncomplicated problem, approximately 30 minutes duration.
98201	Health Hazard Evaluation	Extensive survey and evaluation of problem, may require team of professionals.*
98301	Follow-Up, Limited	Visit to plant to evaluate progress, approximately 3 hours.
98302	Follow-Up Evaluation	Visit to plant to assess progress in a complex situation.
98401	Emergency Visit, On-Site	Visit on short notice to client's location to assist with problem which is urgent.
98431	Emergency Telephone Consultation	Telephonic consultation on an urgent problem not requiring presence on-site, approximately 30 minutes.
98501	Instructional Visit, On-Site	Visit to client's location to arrange or present a scheduled instructional program.
98921	Consultation Service	Time spent in research, report preparation, or conceptualizing approach and solution to problem.

*Members of such a team may include industrial hygienists, safety engineers, epidemiologists, toxicologists, and specialized technical personnel as appropriate.